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professional medical visit companion services

Senior Sidekicks seeks waivers on transportation, case management, and advocacy in order to combine these into our Medical Visit Companion Service (MVC) model. The goal of each of these methods is better outcomes. However, current regulations limit and isolate these functions from each other. The Medical Visit Companion (MVC) model combines all three, and answers two other barriers to healthcare: rural transportation issues and caregiver stress. MVC builds on the managed care model, and adapts it to rural conditions. The waiver's goal is to expand managed care in both depth and coverage to serve the senior population of PSA 7 (Lincolnland AAA) in a two-tiered program: first year Sangamon County; 2nd year: all of PSA7. This arrangement will serve the senior demographic that utilizes the health care system most. Rural transportation and caregiver respite are costs to the medical system not otherwise matchable with current reimbursement schemes. Caregiver stress was not previously identified; as an illness inducer but it is co-morbidity of senior care. Combining these three functions better meets senior and family caregiver needs to catch problems earlier and provide caregivers respite to attend to their own medical care. Both are *intrinsic components* of the MVC model. Although MVC is a non-traditional support, it utilizes current functions. The foundation of MVC is to bridge barriers between medical institutions, clinicians and seniors, care services and seniors, as well as family and senior.

Senior choice actually rests on the senior's *ability* to choose. When non-adherence leads to poor outcomes, the consequences can preclude certain choices. Today's choices are varied and different from those seniors knew as they grew up. It takes time to educate the senior on what today's choices could mean to their way of life. Help to make appropriate choices with the senior requires a professional knowledge of the whole person in a whole system perspective; a unique vantage point of MVC services. To truly bend medicine's cost curve, we must reach for earlier intervention and seek prevention. The MVC model has already developed a profile to identify at-risk seniors and methods to involve them in the service early, *before they develop complex medical needs*. The cheapest form of intervention is prevention; a tenant of MVC.

Medical Visit Companion Model description: Referrals come from seniors, most often from a family member, and occasionally from clinicians. The process begins with a 3-level intake interview which is usually conducted in the senior's home, preferably with a family member present. Superficially, the MVC fills out forms, beginning with the Release of Information (samples provided upon request). These circumstances provide the opportunity for the 2nd level: observation of family dynamics, home, and neighborhood. The MVC makes a 3rd level evaluation of the capacity of the senior and their participation in their medical process. Together, we review the up-coming appointments to observe who made the plans and how they track the schedule. Before the first appointment, the MVC calls the senior. Based on the intake evaluation, the call may be the morning of the appointment if the senior's memory is poor. Usually, medical institutions only call the day before.

The MVC collects the senior at home, preferably coming into the home. Inside, the MVC observes the home, assists the senior with clothing if necessary, or "gives the weather report" to help them decide what to wear. If there are any changes, such as a smell of rotted food or new O.T.C.s, these are noted. Enroute, drive time offers an opportunity for bonding, social interaction, and drawing out the senior about their perceptions of how they are doing. Many times, a senior will tell the MVC that she is *afraid to share certain medical information*. It is part of the MVC's task to help the senior become comfortable with sharing.

During the visit, the MVC takes notes, cross-references data from other visits upon request, ensures that other medical data has been shared such as hospitalizations, or outside medical care. The MVC may remind the senior of their questions, or ask questions the family requested. The MVC, not the senior, may request clinicians to "speak up", explain a term, or better describe a medical process. Where relevant, The MVC *delicately adds* home observations to the clinician's information. Following visits, the senior receives the next appointment card while the MVC double-enters the information in the MVC chart and in their personal calendar. *The MVC chart goes everywhere the patient goes*, crossing all institutions, clinics, and doctors. The trip home is an opportunity for the MVC to review the appointment, discuss the senior's concerns, search for misinformation, and identify any issues which would lead to non-adherence. After each visit, the family receives an email report. Any in-home services also receive a visit report. Fostering cross-system counication is another tenant of MVC.

Contrast between Chicago area and downstate transportation and how it impacts rural medical service delivery: The Chicago area has more medical resources, more variety, closer together, and a public transportation system connecting them. Down state, the medical resources are few, scattered, and much less varied. Transportation is spotty or non-existent, does not cross municipal and county lines, and runs under great restrictions. If medical resources are not locally available, how does the senior access them? If they cannot drive, there is often no alternative. Doctors at Springfield Clinic even ride circuits! In an effort to reach patients, they have created branches in other towns. However, these branches and doctors are not available all days, and do not have all the resources within them. A Jacksonville patient may be seen at the branch and referred for testing to the main clinics in Springfield. The city bus does not provide for disabled persons. The Access bus does some transportation, but it is by appointment, and the person must wait on the corner. That trip to the corner can be difficult in bad weather. Those who are not adjudicated "disabled" are low priority on the Access bus. Taxis may not physically assist those they carry. One bus route goes the Lincoln Land Community College. A veterans clinic moved out of town to be on that bus route. Even with all these limitations, Springfield still has more public transport than many smaller towns in the area. Certain Springfield medical institutions, such as Simmons Cancer Institute, serve all of down state. Able-bodied seniors who drive may not drive on highways, in bad weather, or at night. Sunset on December 6th will be at 3:30pm this year. That means the last appointment time seniors accept is 1:00pm. Just a bad weather report is enough to get seniors cancelling doctor appointments. If they need a prescription renewed, and that prescription requires a prior evaluation or labs, what is the doctor to do? In contrast, MVCs travel to small towns, down county roads, into farms, and across county/municipal lines. MVCs bridge all of these transportation deficits. The goal of the waiver system is to bring all medical care to meet the level of need in all places. The MVC does that for rural care. With today's downstate transportation deficits there is no functional medical home (PCMH) for homes on the range!

Medical Visit Companions encounter and must enable the behavioral health of seniors as well as physical health. Attention to behavioral health is part of the MVC model, from the first conversation before the intake interview. In 1910, there were 6000+ seniors in Sangamon County; by 2010 there were well over 39000+. In 1910, those few seniors knew most of their neighbors. Human bonds of family, religious institutions, and neighbors supported them as they faced losses both personal and medical. The town doctor knew them, and saw them in other settings besides his office. They both spoke English as a first language, and shared the same culture. In 2010, many clinicians down here do not speak English as a first language, do not know this culture, and only meet the senior in medical settings. Under these circumstances, identifying the need for behavioral health interventions is a challenge. The senior challenge is complicated by their medications for physical conditions, social isolation, poor eating, hidden alcohol consumption, dementia, as well as loss of hearing and sight. The added challenge is the senior's belief that "*they are supposed to feel bad; they're old*!" Seniors also believe in-patient care is like "<u>One Flew Over The Cuckoo's Nest</u>". In order to crawl over all these ,challenges, MVC's concentrate on forming a bond of trust and comfort. First, the senior shares the physical side of their care. As the situation unfolds, the MVC looks for opportunities to ask questions and explore emotional issues further. Through that human bridge, the senior is made more comfortable with discussing a psychotropic medication or counseling. Eventually, with the MVC at her side, the senior may be more willing to try a "rehab" hospital stay. Down here, we only have one unit that specializes in senior issues, and it covers all of central Illinois. An MVC's goal is utilization. Options are nothing if they are not utilized. Once an MVC is assigned to the senior, they can <u>only</u> be removed *if the senior requests*. This constant contact ensures continuity of care. Over time, the MVC learns how the senior adapts to changes. When behavioral health issues appear, the MVC is better able to frame the discussion in ways the senior can accept. Modern medicine may have invented the pill in the jar; it is the social motivation that enables the senior to take the pill. We have come full circle, back to the basic intervention of the human bond; the foundation of the MVC model.

Delivery System Transformation: The Medical Visit Companion model takes a whole family approach. MVC recognizes that family caregivers can suffer from "co-morbidities" as a result of the prolonged stress of caregiving e. g: rising cortisol levels and depression to name a few. The caregiving impact is especially hard on older couples, because the caregiving spouse may also suffer from other chronic conditions. The MVC model has *caregiver respite built into it*; not an add-on. If the MVC escorts the ill spouse to the appointment, that is a caregiver respite for the caregiving spouse.

Adult children are not immune from these caregiving consequences. In fact, adult children can become distracted by caregiving and neglect their own care, especially preventive care. They frequently use all their "sick time" from the job to take the parent to the doctor, not themselves. Yet we know that early intervention and prevention are the most economical forms of medical care. Adult children are often in their most productive years. Our society needs them available to rear their own children, and stay on the job. When we lose an adult child who dies from caregiving, or lose their contributions because of caregiving, all society loses. Their parents will still need care, often at public expense, even after the adult child caregiver has died.

Adult children risk falling into poverty as a result of caregiving. A boss cannot fire an employee who joins the Army Reserve, but a boss *can* fire a caregiver. While offering Family Medical Leave is possible, it is not universal. Smaller businesses are exempt, and we have many of those down here. Medical Leave is defined as complete absence for a period of time; it does not cover an extra 15 minutes added to the lunch hour. Yet, an adult child may rush to the parent's home to feed them or see to medications. Adult children have been forced to quit jobs or refuse promotions in order to be available. An adult child who quits working will have difficulty finding a new job at the same level of compensation. Their opportunity to save and invest for their own retirement is diminished. They may have had to spend their savings to cover expenses while they did caregiving. Because the *MVC model has a preventive component*, we bring seniors into the process *before they develop complex medical needs*. We bring caregivers into the model to support and guide them through the caregiving process as it becomes more complex. MVC offers a "Parenting Your Parent" course to help adult children prepare for this transition (think Senior Lamaze). The cheapest form of prevention is empowerment; the ultimate goal of the MVC model. Respectfully submitted, Sara L. Lieber, LSW